Medical Economics

THE GENERAL PRACTITIONER AND PUBLIC HEALTH*

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It is a great privilege and pleasure to be your guest today. For although this is my first visit to Canada I have known your country nearly all my life. As a boy I read books of travel and adventure about Canada and in imagination I canoed on your lakes, fished in your rivers, and hunted in your forests. When I was older I enjoyed the novels of Sir Gilbert Parker and read "How Valmond came to Pontiac" and those wonderful histories of Canada by Parkman, one of the greatest historians who ever lived.

Then I took my medical degree at Oxford, and Oxford in those days was Canada in England, for my Regius Professor there was our beloved Sir William Osler, the physician of two continents. I owe him gratitude for much encouragement and help in my early professional career. As I have said elsewhere: "He advanced the science of medicine, he enriched literature and the humanities; yet individually he had a greater power. He became the friend of all he met—he knew the workings of the human heart, metaphorically as well as physically. He joyed with the joys and wept with the sorrows of the humblest who were proud to be his pupils. He stooped to lift them up to the place of his royal friendship, and the magic touchstone of his generous personality helped many a desponder in the rugged paths of life. He achieved many honours and many dignities, but the proudest of all was his unwritten title, 'the Young Man's Friend'."

I had the privilege of Sir William and Lady Osler's friendship and often stayed with them at their house at Oxford—"The Open Arms", as it was affectionately styled. Here I met many Canadians who have become life-long friends of mine. So you see I have many ties with Canada and I feel today that I am not meeting strangers for the first time but have come amongst friends.

I should like, if I may, to say a few words to you today on the part played by the general medical practitioner in the promotion of public health.

THE ASSOCIATION OF THE PRACTITIONER WITH STATE SERVICES

Ours is a self-denying profession. It is the only one I know of which has as its chief aim the destruction of its means of livelihood. For every advance in medical research, in clinical medicine, and in public health administration tends to reduce the amount of sickness and invalidity in the world and so to diminish the amount of fees paid to doctors. If things go on at the present rate we shall have to introduce the Chinese method of professional payment whereby the client only pays his doctor while he is well. For the present, however, there is plenty for the doctors to do in waging the attack on disease. For this reason we have national medical services, and they are primarily dependent upon the support of the medical practitioner. He is the foundation of a medical service, "its pivot, its anchor, its instrument." In Great Britain it is the general practitioner who recognizes the first case of typhoid or scarlet fever and reports it to the local medical officer of health, or calls in his assistance if he is doubtful about the diagnosis. In this way many an outbreak of infectious disease, which if left unchecked might have assumed serious proportions, is checked at the source by segregation and ascertainment.

The mutual confidence between doctor and patient enables the doctor not only to treat the patient for declared ills but also to advise him how to avoid them. From his knowledge of the individual patient the doctor is the best fitted to prescribe for him rules of conduct, diet, and exercise which are adaptable to his personal needs and capabilities. The practitioner can exert a great influence also for the common weal by familiarizing himself with the available health services and by utilizing them for the benefit of his patients. He should be in close touch with the medical officer of health and the medical officers of the local authority. They for their part should take full advantage of the practitioner's cooperation and should keep him fully informed of the health services, including the aids to diagnosis and treatment in his area.

In addition to his private practice in England and Wales every medical practitioner has definitely prescribed duties to the State. With the development of national organization and interdependence these duties tend to increase. He performs also a number of public medical services. These developments in national health organization do not tend to abolish the private practitioner, nor do they absorb him in a whole-time medical service.

It is no part of British health policy to destroy the mutual confidence and freedom of individual action which exists between doctor and patient. This is specially safeguarded in the National Health Insurance Scheme, under which 16,000 private medical practitioners work. From other State services the private practi-

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tioner is not excluded. Many are employed in the Public Assistance Medical Service, which treats persons who cannot afford to pay for medical attendance. The whole of the Post Office Medical Service is composed of private practitioners. The same is true of certifying factory surgeons. A large number of school medical officers are private practitioners. Although new appointments must be whole-time, many private practitioners are still part-time medical officers of health. Others are employed by local authorities on a part-time basis in the maternity services and in child-welfare clinics. It can truly be said that in Great Britain the private medical practitioner takes a vital and active part in Public Health Services.

I come now to the ways in which the State assists the private practitioner.

UNDERGRADUATE AND POST-GRADUATE MEDICAL EDUCATION

In the course of his medical education he indirectly derives benefit from the grants which the State gives through the University Grants Committee to the Medical Schools of Great Britain.

Further, if the practitioner is to render good service to the community, means must be provided to enable him to continue his education and to keep himself abreast of the advances of medicine. So rapid is this advance that unless a doctor continues his medical education all through his years of practice he soon gets out of date or fails to give or obtain the best forms of treatment for his patient. Consider, for instance, the advances in treatment of diabetes that have followed on the great discovery of insulin by Banting and Best; the use of liver extract which has transformed pernicious anæmia from a fatal into a curable disease; the rapid studies that are being made in chemotherapy and vaccine treatment; the new biochemical tests for disease, and the rapid advances in diagnosis and treatment by radiology. It is essential that the practitioner should have ample opportunity of refreshing his faculties, revising his methods and extending his knowledge.

Impressed with this need the British Government, largely through the personal interest of Mr. Neville Chamberlain, at the time when he was Minister of Health, has established the British Post-graduate Medical School at Hammersmith, London, and provided funds for its maintenance. This school has a distinguished professional and medical staff; it is associated with the British Post-graduate Hospital provided by the London County Council, and already has achieved distinction as a teaching school and centre for post-graduate research. It does not only serve the needs of practitioners in Great Britain, but numbers men and women from all the Dominions and Colonies among its students. Already, I am glad to say, many Canadians have derived benefit from its courses of instruction, and all those who are coming in the future will receive a warm welcome and every facility for study.

In addition to the facilities at the British Post-graduate Medical School a certain proportion of National Health Insurance Funds is applied annually to the provision for insurance practitioners, free from all cost to themselves, of a fortnight's intensive course of clinical study at approved teaching schools and hospitals in Great Britain. Practitioners are able to obtain a free course once in every five years, the grant covering, within specified limits, not only the course fee but, also, travelling and subsistence costs and the cost of a whole-time *locum tenens* where one is required during the doctor's absence from his practice. For the year 1938 it was found possible to allocate about 1,000 practitioners to these courses, and as the facilities for post-graduate education are being increased throughout the country it is hoped in future years that this figure will be greatly exceeded.

THE PROVISION OF SPECIALIST SERVICES

Lastly, there is today in England and Wales a large provision of specialist services by local authorities and at voluntary hospitals which the private practitioner can utilize for the benefit of his patients.

During the greater part of the nineteenth century every qualified medical practitioner was regarded by the public as competent to deal with all branches of medicine, surgery, and obstetrics. In theory this remains true, but the wealth of new knowledge, demanding in its branches individual study, technique, and constant application, makes it impossible for any one man to be an expert in every outlying field of medical territory or to provide from his own resources the elaborate equipment and plant which the modern diagnosis and treatment of many diseases demand. Through the various health services of local authorities, *e.g.*, the Maternity and Child Welfare Service, the School Medical Service, the Orthopædic Service, the Tuberculosis Service, the Infectious Diseases Service, etc., the private practitioner can obtain the assistance of skilled specialists in diagnosing and advising on the treatment of his patients. For ordinary purposes of diagnosis he can obtain, free of charge through the local authorities, the pathological tests which he requires to aid him in the diagnosis and treatment of disease. For instance, swabs are examined for detection of the diphtheria bacillus, and diphtheria antitoxin is provided; Widal tests are done for typhoid; the sputum is examined for tubercle bacilli; specimens are examined by the Wassermann test; and for the gonococcus in suspected cases of gonorrhœa; in cerebrospinal fever there is examination for the meningococcus and provision of anti-serum for treatment; for tetanus anti-tetanic serum is provided. Local authorities are now being urged by the Ministry of Health to make increased laboratory provision, so that every modern pathological aid may be available

for the diagnosis and treatment of disease in all parts of the country.

Then there are the increasing hospital services, both those established by local authorities as well as voluntary authorities, to which the private practitioner can refer his patient.

While more development of these services is required, it is probably true that to a large extent facilities are already available in London and our other large cities by which most persons who require it receive specialist advice and specialist hospital treatment. In the provinces (except in certain areas) these services still need organization, coordination, and further development in order that they may be utilized to the full needs of practitioners for specialist advice on their patients.

CONCLUSION

The point I want specially to make is that all this system of national health services in Great Britain does not oust the general practitioner. Far from it. It enables him to secure the best modern advice and facilities for his patients of which they would otherwise be deprived. The general practitioner is the first line of defense in a national health service, and in medical education, post-graduate instruction and specialist aid he obtains recognition from the State of his invaluable work.

Medical Care for Low-income Farm Families

At the annual meeting of the Nova Scotia Medical Society, held at Digby, N.S., on June 5th and 6th, Dr. R. C. Williams, of the United States Public Health Service, Washington, D.C., presented a most interesting paper on "Medical care plans for low-income farm families". Dr. Williams is the moving medical spirit in the work carried out in the United States by the Farm Security Administration to rehabilitate more than 700,000 low-income and destitute farm families, victims of the depression. This body developed plans for medical care because it found that good health is a necessary part of a family's economic rehabilitation. Trained advisors help the farmers plan, and loans are made to them by the government so that they can finance their programs. These loans average about $3,000 annually, and experience has shown that they are generally repaid.

All medical care plans are set up in agreement with the state and local medical societies. They are based on the borrower's ability to pay for medical services, as determined by his farm plan; on free choice of participating physicians, and on the setting aside of funds, in the hands of a trustee, at the beginning of the operating period. The usual payment is between $15 and $30 a year per family, being based on the family's expected income. Under the plan most generally used, a part of the pooled funds is allocated for hospitalization and emergency needs, including surgical care. The remainder is then divided into equal monthly allotments for the period covered. Physicians submit monthly statements to the trustee for services rendered. If the total bills for the given month exceed the amount available all bills are proportionately reduced and each physician is paid his *pro rata* share. He may be reimbursed at a later date from a balance created when the fund exceeds the demands upon it. In the second plan, funds in the hands of the trustee are kept separate for each family.

Both plans encourage a sane acceptance of preventive medicine. Most families, doubtful at first about paying for medical care they might not need, now feel that the security is worth the investment. In many areas local physicians previously have served these same people with little or no compensation. Fears were voiced that participating families would abuse their privilege by requesting unnecessary medical attention, but this abuse has been met only in rare instances.

Dr. Williams presented figures to illustrate the work and went on to speak of the particu'ar problems met in different areas, and their solutions. The program, he said, does not present a final answer to all the problems of medical care in rural areas, but as a worthwhile example, as indeed it is, of methods which may be used in approaching these problems.

At the same meeting the Committee on Medical Economics, under Dr. H. B. Atlee, advised careful consideration of any plans of health insurance. Two hospitals have offered group insurance, and two schemes for practitioners have appeared. The Committee finds them all faulty. They consider $15.00 to $18.00 per family, per year, as the lowest possible fee the practitioner should consider. $24.00 is an improvement, but neither is good. The additional fee of $10.00 for a maternity case makes thorough prenatal care impossible.

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